

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/01/2014
NAME OF PROVIDER OR SUPPLIER VIBRA HOSPITAL OF NORTHWESTERN INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 9509 GEORGIA ST CROWN POINT, IN 46307		
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S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00158293</p> <p>Substantiated: deficiency cited related to allegations.</p> <p>Date: 12/1/14</p> <p>Facility Number: 012131</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>QA Review: JLee 12-10-14</p>	S 000		
S 930	<p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, observation, and personnel interview, nursing staff failed to supervise and evaluate the nursing care for each patient related to inconsistent and/or incomplete wound documentation for 2 of 5 (Patient #1) open patient medical record and (Patient #3) closed patient medical record reviewed; and lack of weekly Interdisciplinary Team Care</p>	S 930		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 930	<p>Continued From page 1</p> <p>Conferences/Meetings and representation by a Wound Care Team member at the meetings for 2 of 5 (Patient #1) open patient medical record and (Patient #3) closed patient medical record reviewed; and lack of providing patients with a daily bath or am/pm care for 2 of 5 (Patients #1 and #2) open patient medical records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Policy titled "Guidelines for Nursing Care" revised/reapproved 3/24/14; "Skin Integrity and Pressure Ulcer Prevention Plan" revised/reapproved 1/5/13; and "Photographs and Measurements" revised/reapproved 2/13, were reviewed on 12/1/14 at approximately 3:00 PM, and indicated wounds will be photographed and measured weekly. Documentation will also be completed for type of wound, location, measurements, exudate type and amount, odor description, periwound/dressing appearance, wound bed appearance, and pain score. 2. Policy titled, "Interdisciplinary Team Care Conferences/Meetings" revised/reapproved 2/14, was reviewed on 12/1/14 at approximately 3:00 PM, and indicated meetings will be held weekly and a member from Wound Care should be included. 3. Policy titled, "Guidelines for Nursing Care" revised/reapproved 3/24/14, was reviewed on 12/1/14 at approximately 3:00 PM, and indicated daily bathing and/or am/pm care is to be provided to patients. 4. Review of open and closed patient medical records on 12/1/14 at approximately 1147 hours, confirmed: A. Patient 1: 	S 930			

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S 930	<p>Continued From page 2</p> <p>a. had pictures taken of a coccyx pressure ulcer, and right and left buttock (type of wound not documented on picture form) on 10/14/14 (date of admission). Pictures of these areas were taken again on 10/31/14 and were not taken weekly after this as required by facility policy and procedure. Also, documentation on the Bates-Jensen Wound Assessment Tool is for 10/15/14 and 10/31/14 for these areas and is not documented weekly according to facility protocol. Furthermore, Patient Care Notes dated 10/15/14 described patient 1's wounds as "high risk for breakdown bilateral buttock at rectal fold has DTI (deep tissue injury) to both sides with left revealing stage 2 areas..." On 10/18/14, coccyx/buttocks were described as red, intact blister, wound cleansed, treated, and dressed as ordered. Then again on 10/31/14 assessed as, "stage 2 to left buttock at rectal fold, discoloration to the right buttock along rectal fold and a stage 2 to the crease..." A skin assessment on 11/3/14, 11/13/14 0026 hours and 2001 hours, 11/14/14, 11/17/14, 11/19/14, lacked type of wound, location, exudate type and amount, odor description; and/or periwound/dressing or wound bed appearance, and pain score. Other nursing note areas in the MR had the skin documented as intact and/or not documented at all. Patient 1 was still currently in the facility.</p> <p>b. Interdisciplinary Team Care Conferences/Meetings lacked documentation of representation by a Wound Care Team member on 10/22/14, 10/29/14, 11/5/14, and 11/12/14 and lacked weekly documentation of these types of meetings for the weeks after 11/12/14.</p> <p>c. lacked documentation of daily bathing and/or am/pm care that included a warm wash cloth, oral care, combing hair or shave on 11/2/14, 11/7/14, 11/14/14, and 11/15/14.</p>	S 930		

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S 930	<p>Continued From page 3</p> <p>B. Patient 2 lacked documentation of daily bathing and/or am/pm care that included a warm wash cloth, oral care, combing hair or shave on 11/28/14.</p> <p>C. Patient 3:</p> <p>a. had pictures taken on 10/17/14 (date of admission) of 4 surgical wounds on the right upper arm, right axilla, right mid arm, and left shoulder. Pictures of a scrotal abcess were also taken on 10/17/14. These pictures were taken again on 10/27/14, but were not taken after this and patient was discharged on 11/14/14. Wound Team Visit documentation dated 11/9/14 indicated 4 surgical wounds as right shoulder, right shoulder distal incision, right anterior upper extremity, and right anterior upper extremity distal wound; and 3 other wounds as scrotum, scrotum posterior, and scrotum right lateral. Patient Care Notes dated 10/20/14 described patient 3's wounds as "cancerous wounds to scrotum and surgical wounds to right shoulder and upper extremity. The incisions to the right shoulder and upper extremity have staples all intact with no redness or drainage noted. All shoulder wounds are okay open to air or have border gauze as dictated by the patient. The cancerous wound to anterior scrotum is hypergranulated and red with small amount of purulent drainage noted. The wounds to the posterior and right lateral scrotum appear to be abscess in nature and are excreting a purulent exudate. Scrotal wounds to anterior and posterior were packed with iodoform gauze and the lateral was treated with a dry gauze to collect the drainage. The periwound skin was protected Calazime ointment, ABD pads were used to keep dressings in place and dry, supported by under wear to keep dressings in place." Patient Care Notes dated 10/24/14, 10/25/14, 10/26/14, document a posterior penile</p>	S 930			

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S 930	<p>Continued From page 4</p> <p>wound and scrotal and penis wounds, but do not address any other wounds. On 10/29/14, Wound Care Treatment Record documents a wound as pale, intact, serous drainage, no odor, but lacks location of wound. On 11/6/14, Wound Care Treatment Record documents wound as scrotal area, but does not address any other wounds. Again on 11/7/14 Wound Care Treatment Record lacks location of wound. On discharge date of 11/14/14, "wound to anterior scrotum has a cancerous wound bed, and very vascular, the depth was not measured as simple cleansing was causing a moderate amount of bleeding. The patient was cleansed and dry gauze was tucked under the penis to hold the gauze in place...coccyx was assessed and found to be intact as were the bilateral heels." Wound Team Visit dated 11/14/14 documented surgical wounds as healed and scrotal wounds as above. Other nursing note areas in the MR had the skin documented as intact and/or not documented at all.</p> <p>b. Interdisciplinary Team Care Conferences/Meetings lacked documentation that they were held weekly and lacked documentation of representation by a Wound Care Team member during length of stay 10/17/14 through 11/14/14.</p> <p>5. Staff #4 (Registered Nurse, R.N.) was interviewed on 12/1/14 at approximately 1430 hours, and confirmed for patients 1 and 3 that the wound care documentation is inconsistent throughout the MR and that the patient's wounds should have been photographed weekly during patient's stay. Wound assessments should also include This information was either lacking or inconsistent for these patients and facility policy and procedure was not followed. Also, confirmed for patients 1 and 2 that daily bathing and/or</p>	S 930		

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S 930	Continued From page 5 am/pm care was not provided as required by facility policy and procedure. 6. Staff #5 (R.N., Wound Ostomy Continence Nurse) was interviewed on 12/1/14 at approximately 1325 hours, and confirmed for patients 1 and 3 that Interdisciplinary Team Care Conferences/Meetings were not held consistently every week and lacked representation by a Wound Care Team member for patients who had diagnoses of wounds and/or pressure ulcers as required by facility policy and procedure.	S 930			